		HAND HUMAN SERVICES E & MEDICAID SERVICES				FOR	D: 11/02/2009 M APPROVED D. 0938-0391
	T of Deficiencies Of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE	
		09G123	B. W#	NG		1	R-C 1 <b>6/2009</b>
	PROVIDER OR SUPPLIER  JAL DEVELOPMENT	INC.		43	EET ADDRESS, CITY, STATE, ZIP CODE 31 53RD STREET, SE (ASHINGTON, DC 20019		10-00-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD SE	(X5) COMPLETION DATE
	from DC Health Reconsultant with Dep (DDS). The e-mail to the health and sa facility. A nurse with Partnership (DCHR deficient practices at 1. There was no Li or Registered Nurse 7:00 a.m. and 7:30 pass medications a a.m. All scheduled at 2. A client, that was diabetic, had been a having her blood su checked the client's availability of a land reading was 127. The notified and ordered held;  3. There were no la perform blood sugar 4. There was a note medical record betworder and medication Due to the nature of facility's status of be identified on Septem.	9, HRLA received an e-mail sources Partnership, a partment on Disability Services documented concerns related afety of a client residing in the in the DC Health Resources (IPN) alleged observing systemic as specified below:  censed Practical Nurse (IPN) a (RN) in the home between a.m. The LPN scheduled to invived some time after 8:00 medication passes were late; an insulin dependent given her breakfast without igar measured. The LPN is blood sugar, without the et and the client's blood sugar ne primary care physician was if that the morning insulin be uncets available in the home to refinger sticks.  If discrepancy in one client's mean the written physician's in administration record.	{W 0	(00)	GOVERNMENT OF THE DISTRICT DEPARTMENT OF HEAL HEALTH REGULATION ADMINI 825 NORTH CAPITOL ST., N.E., WASHINGTON, D.C. 201	_TH  STRATION 2ND FLOOI	
BORATORY	the State Survey Agrinvestigation on Octor investigation, concer revealed the facility in DIRECTOR'S OR PROVIDE	ency (SA) initiated an onsite ober 7, 2009. During the ms were identified that nad not enacted sufficient SNSUPPLIER REPRESENTATIVE'S SIGNA	TURE		兀哇		(%) DATE
-1/2	myma	w			MUS	111	18/81

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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PRINTED: 11/02/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING R-C B, WING 09G128 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 481 59AD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (XS) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG DEFICIENCY (W 000) Continued From page 1 (W 000) systems to remove the Immediate jeopardy and therefore, clients' health and safety continued to be at risk. On October 13, 2009, the SA received an allegation of compliance indicating that the immediate jeopardy had been removed. Observation and interviews on October 14, 2009. and October 15, 2009, however, revealed continued deficient practices existed related to the health and safety of the clients and the immediate jeopardy remained in effect. On October 16, 2009, the facility removed the immediate jeopardy by taking immediate and aggressive actions to remedy the problems as evidenced by the following: a. LPN #1 was removed from work schedule and was scheduled to be terminated by October 19, 2009: b. RN #1 was removed from the work schedule pending further corrective action; c. The facility indicated that corrective actions would be implemented to address the DON's failure to supervise and provide adequate oversight of nursing care services. The findings of the survey were based on observations in the group home, interviews with the facility's management, nursing and direct care staff and the review of records, including unusual incident reports, investigation reports and administrative records. Three clients with various disabilities were selected from a residential

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population of six females.

While the facility implemented practices to

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A, BUILDING R-C B. WING 09@123 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (X8) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY {W 000} Continued From page 2 (W 000) address the immediate jeopardy, condition level deficiencies remained in the domain of Governing Body and Health Care Services. {W 102} 483,410 GOVERNING BODY AND (W 102) MANAGEMENT The facility must ensure that specific governing W102 body and management requirements are met. This Condition will be met as evidenced by: 11-12-06 This CONDITION is not met as evidenced by: Reference responses to W104 and Based on observation, interview, and record W331. ONGOIN review, the facility's governing body failed to maintain general operating direction over the facility. [See W104 and W331] The effects of these systemic practices resulted in the governing body's failure to adequately manage the facility in a manner that would ensure each client's health and safety. [See also W318] {W 104} 483.410(a)(1) GOVERNING BODY {W 104} W104 The governing body must exercise general policy, This Standard will be met as evidenced budget, and operating direction over the facility. by: 1. Cross reference responses to This STANDARD is not met as evidenced by: 11-18-45 Based on observation, interview and record W102 review, the governing body exercised general 2. Reference response to W149 policy and operational direction over the facility, except in the following areas for three of three Reference response to W192. clients residing in the facility. (Clients #4, #5, and Reference response to W331. #6).

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The findings include:

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(W 114)

clients residing in the facility.

483.410(c)(4) CLIENT RECORDS

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(W 114)

ensure compliance in this area.

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09G123	B. WING_		l.	16/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	4	REET ADDRESS, CITY, STATE, ZIP CODE 491 53RD STREET, SE WASHINGTON, DC 20019		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	MILDRE	(XE) COMPLETION DATE
W 149) Continued From page 5 policies and procedures that prohibit mistreatment, neglect or abuse of the client.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure telephone orders were signed and dated within the 24 hour period, for three of the six clients residing in the facility. (Clients #4, #5, and #6)  The finding includes:  On October 13, 2009, the facility submitted a Ptan of Correction (POC) to address deficiencies cited as a result of the October 1, 2009 survey. On October 1, 2009, the facility was cited for Implementing policies that ensure the health and safety of the clients residing in the facility. According to the POC, the facility documented that it would ensure physician's orders were signed and dated within 24 hours.  1. The facility falled to have a policy to ensure that physician's telephone orders were signed and dated within 24 hours as required by local regulation [Title 7, Subtitle D, Chapter 13].  a. Review of Client #5's medical record on October 7, 2009, at approximately 8: 15 p.m., revealed a telephone orders dated September 29, 2009. According to the orders, the client was prescribed Debrox five drops to both ears, twice a day for five days. Further review of the telephone order revealed no evidence that the order was signed by the primary care physician (PCP). Interview with the registered nurse (RN) on October 7, 2009 at approximately 7:00 p.m. indicated that telephone orders should be signed	{W 149}	<del> </del>	n to d dates y is e LPN LPN RN ns arise. review k up ss to staff nal	10.16.09 ongoing

PRINTED: 11/02/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XJ) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING R-C B. WING 09G123 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX (X5) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY {W 149} Continued From page 6 (W 149) within 24 hours by the PCP. b. Review of Client #4's medical records revealed a telephone orders dated September 19, 2009. The order read, "Cleanse scratch on the forehead with peroxide, apply Neosporin cintment every shift until healed." Further review of the telephone order revealed no evidence that the order was signed or dated by the PCP. Interview with the registered nurse (RN) on October 7. 2009 at approximately 2:00 p.m. indicated that telephone orders should be signed within 24 hours by the PCP. c. Review of Client #4's medical record on October 14, 2009 at approximately 10:00 a.m., revealed a telephone orders dated October 8. 2009 at approximately 3:15 p.m. According to the orders, the client was prescribed Fosamax 70 mg, one tab, by mouth, every week on Wednesday for osteoporosis. Further review of the telephone order revealed no evidence that the order was signed by the primary care physician (PCP). Interview with the registered nurse (RN) on October 8, 2009 at approximately 4:00 p.m. indicated that telephone orders should be signed within 24 hours by the PCP. d. Review of Client #4's medical record on October 14, 2009 at approximately 10:00 a.m., revealed a telephone orders dated October 8, 2009 at approximately 3:15 p.m. The order read discontinue 17 units Lantus subcutaneously (SQ) at bedtime for diabetes mellitus; Given Lantus 10

units SQ at bedtime for diabetes mellitus; and discontinue 1/2 diet pudding at bedtime; and give 4 ounces apple juice and one graham cracker. Further review of the telephone order revealed no evidence that the order was signed by the primary

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING R-C B. WING 09Q123 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, 9E INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX DATE TAG TAG DEFICIENCY **(W 149)** Continued From page 8 (W 149) #4, #5, #6, and #7) The findings include: The facility failed to have a policy to ensure that physician's telephone orders were signed within 24 hours as required by local regulation [Title 7, Subtitle D, Chapter 131. Review of the physician's orders sheet (POS) on September 30, 2009 at approximately 1:10 p.m. revealed Client #1 had several telephone orders that had not been signed by the facility's Primary Care Physician (PCP) within twenty-four (24) hours as required by local regulation: a. September 9, 2009 at 8 p.m. -Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days; -Cleanse stomach stoma with NSS, pat dry apply Bacitracin 500 units to G-tube site twice daily, cover with dressing. b. September 13, 2009 at 3:30 p.m. -Bactrim DS via G-tube BID x 10 days for MRSA. Monitor vital signs twice daily x 10 days. D/C Keflex-bacteria is resistant to Keflex. September 14, 2009 at 3:00 p.m. -D/C Bactrim, start Avelox 400 mg QD x 7 days. d. September 23, 2009 at 6:30 p.m.

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-Start Peptamen DT @ 50 cc 1 hr x 10 hours from 7 p.m. to 5 a.m. D/C Osmolite 1.2 CAL from

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2. The facility's medication nurse failed to use the appropriate adaptive feeding equipment during

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staff on a regular basis.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		lULTIPI LDING	LE CONSTRUCTION	(X3) DATE S	
		09G123	B. WI				7-C 1 <b>6/2009</b>
	PROVIDER OR SUPPLIER UAL DEVELOPMENT,	INC.		431	ET ADDRESS, CITY, STATE, ZIP CODI 1 59RD STREET, SE ASHINGTON, DC 20019		14245
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST SE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERÊNCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
ł	Review of Client #5 22, 2009, revealed be thickened to neo current physician or confirmed the necta  It should be noted to training records on approximately 3:00 care staff received to protocol on August care staff failed to p thickened liquid con 4. On October 7, 20 observed eating din shredded chicken, s Interview with the di meal, indicated that texture diet.  Review of Client #49 January 22, 2009, re diet. Further review physician orders dat the mealtime protoc Review of the facility October 8, 2009, at revealed staff had re diet and feeding prot However the direct o proper diet consister	its feeding protocol dated April that all liquids were ordered to star consistency. The client's reders dated October 2009, at thickened liquid consistency. That the review of the facility's October 8, 2009, at p.m., revealed that the direct training on Client #5's feeding 28, 2009; however the direct training on Client #5.  109 at 6:33 p.m., Client #4 was ner. The meal consisted of siliced carrots and rice. rect care staff, during the the client receives a chopped seedled a chopped texture of the client's current ted October 2009, confirmed	{W 1	92}	schedule and coordinate training with incoming restaff and provided on-go training thereafter. Cor actions will be taken for employees who fail to consistently participate meet training requirements.	nursing bing rective	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/02/2009 I APPROVED : 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION ING	(X3) DATE S COMPL	ETED
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NAME OF F	ROVIDER OR SUPPLIER			<b>ST</b>	FREET ADDRESS, CITY, STATE, ZIP CODE		
INDIVIDI	JAL DEVELOPMENT,	INC.		1	431 53RD STREET, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X6) COMPLETION DATE
(W 192)	Continued From pa	ge 12	{W 1	92	1		
,	transcribe orders, a	ssess weights, and, sedings. This failure posed	(** )	36,			
	The findings includ	<b>e</b> :					
	that each licensed s	sing services failed to ensure taff had received training on rately measure the clients'					
	from 88.7 pounds in April 2009. The clien had lost an addition:	crease in her body weight March 2009 to 62 pounds in ht, as of September 29, 2009, all pound, placing her below Range (HWR 62-62 lbs).					
	interviews were con- and Director of Nursinformation. Accordi- variations had been the clients residing in suspected that weigh and/or measured ac The RN supervisor for weighing policy had accuracy of weights enact if warranted. (DON) revealed that had provided training correct policy and pro- clients' body weights scale to ensure that measuring weight.	ducted with the RN supervisor ing to ascertain more ng to RN Supervisor, weight documented for several of a the facility and it was ht's had not been completed curately in previous months. When the indicated that the been revised to ensure and to identify measures to the Director of Nursing the Supervisory nursing staff to the nursing staff on the occdure for measuring, to include calibration of the the scale was accurately					
ļ:	September 30, 2009	the LPN and the QMRP on revealed that a new scale, Interdisciplinary Team (IDT)					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING R-C B. WING 09G123 10/15/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 59RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX (X5) COMPLETION PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) (W 192) Continued From page 13 {W 192} had been ordered, but had not been received. The QMRP indicated that the scale currently being used in the facility had been calibrated and was accurate. The QMRP also indicated that all nurses had been trained in its use. When the LPN on duty was asked to demonstrate the weighting techniques, she failed to following the weighing protocol that required the scale to be calibrated prior to placing the individual on the scale. The QMRP acknowledged that the LPN failed to following the weighing protocol. The RN was asked to provide evidenced that all nurses had been trained to weigh clients using the chair scale. The RN could not provide any documentation of training. 2. Similarly, interview with the nurses indicated that the Supervisory RN and Director of Nursing had trained nursing staff on tube feeding procedures for Client #1. This reportedly addressed changes in the client's tube feeding schedule. Although it was stated that nurse training records would be documented in the in-service training book, subsequent review of the training records failed to show evidence of said training on tube feeding procedures. No additional information was provided; therefore, a chronological history of nurse training on the facility's weighing and G-Tube feeding protocol could not be verified. It should be noted that this is a repeat deficiency. 3. Cross Refer to W331 (#1a.b.c). The facility failed to ensure nursing staff were effectively trained to transcribe physician's orders accurately.

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PRINTED: 11/02/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING R.C B. WING 090123 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PRÉFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC (DENTIFYING INFORMATION) TAG DEFICIENCY **(W 192)** Continued From page 14 (W 192) 2. Review of Client #1's record on September 30. 2009 evidenced physician orders (dated September 1, 2009, and September 9, 2009. September 23, 2009 September 29, 2009) that were transcribed inaccurately, which could likely posed a risk to the clients' health and safety. According to the Director of Nursing (DON), the supervisory nursing staff had provided training to all nursing staff on and after the August 25, 2009. on the importance of transcribing physician orders' accurately. Review of the in-service training records, however, failed to show evidence of said training on transcribing of all physicians' orders. The DON acknowledged that the physician's orders were transcribed incorrectly and that nursing in-service training session were ineffective. 3. Cross-refer to W331.6 The facility's nursing services failed to ensure that each licensed staff had received training on procedures to properly calculate fluid restrictions for Client #2 and #3, as ordered by the Primary Care Physician (PCP). Review of Clieπts #2 and #3's Fluid Restriction intake Sheets on September 30, 2009 at approximately 4:00 p.m. revealed inaccuracies with the amounts of fluids received. a. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Client #2 was prescribed a fluid restriction of 880 's cc of fluid daily. Review of Client #2's physician orders verified the

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client was prescribed a fluid restriction of 880 cc

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB\_NO. <u>0938-0391</u> (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING R-C B. WING 09G123 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION **(X5**) ID PREFIX COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY) {W 192} (W 192) Continued From page 15 of fluid daily. Review of the documentation utilized by nursing staff ( i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. mealtime protocol) at approximately 3: 40 p.m. revealed the client's total allotted daily fluids intake measured 920 cc daily. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:00 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 880cc of fluid dally as prescribed. b. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Client #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Client #3's physician 's orders, verified that the client was prescribed a fluid restriction of 1500 cc of fluid daily. Review of the documentation utilized by the nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. Mealtime Protocol) at approximately 3:45 p.m. revealed the client 's total allotted daily fluid intake measured 1720. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:10 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 1500cc of fluid daily as prescribed. Although it was stated that nurse training records would be documented in the in-service training book, subsequent review of the training records

PRINTED: 11/02/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING R-C B. WING 09G123 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX DATE TAG TAG DEFICIENCY) (W 192) Continued From page 16 (W 192) failed to show evidence of said training on fluid intake/restrictions. 483.460 HEALTH CARE SERVICES {W 318} {W 318} W318 The facility must ensure that specific health care This Condition will be met as services requirements are met. evidenced by: Reference responses to W331, This CONDITION is not met as evidenced by: W368, and W192. The Medical 11:18:09 Based on Interviews, and record verification, the Director in coordination with the facility's nursing services failed to establish Myoing systems to provide health care monitoring and DON will continue to evaluate Identify services in accordance with clients' needs and assess and implement [Refer to W331]; the facility failed to assure that all drugs are administered in compliance with the policies and protocols to ensure physician's orders [Refer to W368]; and the that health care practices, to facility failed to ensure that nurses were were include; monitoring, identifying competent to provide nursing services (Refer to W1921. services in accordance with clients needs, medications The results of these systemic practices results in the demonstrated failure of the facility to provide administered, compliance with health care services. the physician's orders, competency and systemic practices analyzed and addressed to ensure that health care services are met. Based on interviews, and record verification, the facility's nursing services failed to establish

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systems to provide health care monitoring and identify services in accordance with clients' needs [Refer to W331]; the facility's registered nurse (RN) failed to ensure direct physical examinations were conducted quarterly or on a more frequent basis [Refer to W336]; the facility failed to assure

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (XZ) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R-C B. WING 093123 10/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY Continued From page 17 {W 318} (W 318) that all drugs are administered in compliance with the physician's orders [Refer to W368]; the facility's nurse failed to store drugs under proper conditions of security, during the medication administration [Refer to W381]; and the facility failed to ensure that nurses were were competent to provide nursing services [Refer to W192]. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services. W331 (W 331) {W 331} 483,460(c) NURSING SERVICES This Standard will be met as evidenced The facility must provide clients with nursing services in accordance with their needs. by: 1. Cross reference responses to This STANDARD is not met as evidenced by: W192 Based on observation, interview and record review, the facility failed to ensure nursing serves 2. Cross reference responses to in accordance with each client's needs, for three W436. of the six clients residing in the facility. (Clients #4, #5, and #6) 3. Cross reference response to W192 (2) The findings include: 4. Cross reference response to October 1, 2009, the facility was cited for failure W192 (3) to ensure employees providing nursing services, were trained to competently transcribe orders. assess weights, calculate fluid restriction and administer G-tube feedings. On October 13, 2009, the facility submitted a Plan of Correction (POC) which stated that all nurses in the home would receive additional training on appropriate transcribing of physicians' orders, adherence to the medication administration policy, documentation and communication between the primary care physician (PCP), ensure consistency

with mealtime protocols in accordance to

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FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING R-C B. WING 09/3123 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY {W 331} Continued From page 18 (W 331) physician orders and addressing nutrition recommendations. W331, continued... 1. Cross Refer to W192. The facility failed to ensure nursing staff were effectively trained to 1-6 transcribe and review physician's orders accurately. (Client #4 and Client #5) The Director of Nursing Implemented disciplinary action for the RN who 2. Cross Refer to W436. The facility nurses falled to transcribe telephone orders failed to follow-up on medical consultation order 11),4109 for custom molded shoes for Client #4. when given. The Director of Nursing Myani also provided additional training for 3. The facility's medication nurse failed to use the all RN staff to include but not limited appropriate adaptive feeding equipment during medication administration for Client #5 to: ongoing supervision requirements, timely During medication administration observation on assessments/follow-up. October 14, 2009 at 9:15 p.m., the Licensed documentation and communications Practical Nurse (LPN) was observed administering Client #5 her medications using a with the PCP. The RN will conduct regular cup. The liquid was observed to spill from assessments at discharge for each the client's mouth. During dinner observations on individual and document in the October 14, 2009 at 5:35 p.m., the direct care record. All physician orders are to staff was observed assisting the client with drinking using a spout cup. Further observations be reviewed by the RN for accuracy revealed no spillage during the meal. Interview with regular reviews and monitoring with the direct care staff on October 14, 2009. by the Director of Nursing to further during the meal revealed that the client required a spout cup during feeding to reduce spillage. ensure compliance with the Review of the Client #5's feeding protocol dated standards. The RN in coordination April 22, 2009, verified the staff's interview by with the Director of Nursing will revealing the client should be fed with an adaptive spout cup to reduce spillage. monitor implementation of the POS. provide training on g-tube feedings, 4. During dinner observations on October 7, and medication administration to 2009 at 6:33 p.m., Client #4 was observed eating. include competency reviews. Client The meal consisted of shredded chicken, sliced #1 no longer resides in the home. carrots and rice. Interview with the direct care staff, during the meal, indicated that the client

PRINTED: 11/02/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED ОМВ №. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING R-C B. WING 09G123 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (XIS) COMPLETION DATE (X4) ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) (W 331) Continued From page 19 (W 331) receives a chopped texture diet. Review of Client #4's mealtime protocol dated January 22, 2009, revealed a chopped texture diet. Further review of the client's current physician orders dated October 2009, confirmed the mealtime protocol. Review of the facility's training records on October 8, 2009, at approximately 3:00 p.m., revealed that the staff received training on Client #4's diet and feeding protocol on August 28, 2009. However the direct care staff failed to provide the proper diet consistency to Client #4. Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for three of three clients in the sample. (Client #1, Client #2 and Client #3) The findings include: 1. The nursing staff failed to transcribe Client #1's physician's orders accurately, which could likely pose a risk to the clients' health as evidence by the following: a. Interview with the nursing supervisor on September 30, 2009 at 8:45 a.m. revealed that Client #1 was hospitalized from September 15. 2009 through September 23, 2009 for elevated

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temperature and PEG tube infection. Further Interview revealed that the RN supervisor had contacted the Primary Care Physician (PCP) upon the client's return to the group home and received an order to "resume all previous orders".

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDEN OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.    CAN ID   SUMMARY STATEMENT OF DEFICIENCIES   STREET ANDRESS, CITY, STATE, ZIP CODE   STREET, SE   WASHINGTON, DC 20019		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPLE CONSTRUCTION		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.  SUMMARY STATEMENT OF DEPICIENCIES CRACH DEPICEMENT WAS THE PRECIDED BY PULL REGILATORY OR LES DEPICIFY HIS PRECIDED BY PULL REGILATORY OR LES DEPICEMENTON)  REGILATORY OR LES DEPICEMENTON  REGILATORY OR LES DEPICEMENTON  REGILATORY OR LES DEPICEMENTON  TAA  CONTINUED From page 20  Review of Cilient #1's record at approximately 9:00 a.m. revealed a readmission order that indicated "orders valid for 120 days. Resuming all pravious orders, T. O. (Relaphone order) PCP reviewed by RR supervisor 9/230.9°. Additional handwritten orders, dated September 23, 2009 Were discovered in the nurses' station by Licensed Practical Nurse (LPN) #1 that were more specific and identified discharge orders that were not signed by the transcriber or the physician. The Register Nurse (RN) stated that she received the telephone orders from the PCP between 4 p.m. and 5 p.m. and acknowledged that she had given the RN supervisor a telephone order to resume all previous orders. At the time of the Investigation, the facility's RN failed to transcribe telephone orders as given.  b. Review of a physician order dated September 1, 2009 at approximately 5:55 am revealed the client was to receive Dilamin chewable tables (U-D 80 mg tablets), 2 tablets crushed via G tube feeding for 1 hour before and after administration of Phenytoin. Review of the corresponding Medication Administration Record at 9:00 a.m. revealed that the client was receiving her G-tube feeding from 6 p.m. to 6 a.m.  Review of the Medication Administration Record (MAAR), however, revealed that the licient twas being administration administration in an inference (MAAR), however, revealed that the client twas being administration Revealed LID 50 mg 2 tablets, via G-tube at 6 AM. In an inference				1 .		-	R-C
INDIVIDUAL DEVELOPMENT, INC.    SUMMARY STATEMENT OF DEPICIENCIES   PROVIDERS   PROVIDERS PLAN OF CORRECTION   PREFEX   PROVIDERS   PROVIDERS PLAN OF CORRECTION   PROVIDERS PLAN OF CORRECTION   PROVIDERS PLAN OF CORRECTION   CANCELL PROVIDERS PLAN OF CORRECTION   CANCELL PROVIDERS PLAN OF CORRECTION   CANCELL PROVIDERS   CROSS-REPERRINADE TO THE APPROPRIATE   CANCELL PROVIDERS   CANCELL PROVIDE			09G123	B.WW	IG	10	_
REGULATORY OR LISC IDENTIFYING INFORMATION)  Review of Client #1's record at approximately 9:00 a.m. revealed a readmission order that indicated "orders valid for 120 days. Resuming all previous orders, dated September 10. Licensed Proximation of			INC.		431 53RD STREET, SE		
Review of Client #1's record at approximately 9:00 s.m. revealed a readmission order that indicated "orders valid for 120 days. Resuming all previous orders, 1-70. (telephone order) PCP reviewed by RN supervisor 9/23/09." Additional handwritten orders, deted September 23, 2009 were discovered in the nurses' station by Licensed Practical Nurse (LPN) #1 that were more specific and identified discharge orders that were not signed by the transcriber or the physician. The Register Nurse (RN) stated that she received the telephone orders from the PCP between 4 p.m. and 5 p.m. and acknowledged that she had not transcribed the telephone order from the PCP when it was given to her.  On 9/30/09 at approximately 3:30 p.m. contact was made with the PCP via phone which verified that he had given the RN supervisor a telephone order to resume all previous orders. At the time of the investigation, the facility's RN failed to transcribe telephone orders as given.  b. Review of a physician order dated September 1, 2009 at approximately 8:55 am revealed the olient was to receive Dilantin chewable tablets (U-D 50 mg tablets), 2 tablets crushed via G tube everyday at 7 am. for seizure disorder, hold tube feeding from 1 hour before and after administration of Phenytoin. Review of the corresponding Medication Administration Record at 9:00 a.m. revealed that the client was receiving her G-tube feeding from 6 p.m. to 6 a.m.  Raview of the Medication Administration Record (MAR), however, revealed that the client was being administered Dilantin chewable U-D 50 mg 2 tablets, via G-tube at 6.4 M. In an interview	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIATE	
		Review of Client #7 9:00 a.m. revealed indicated "orders vali previous orders, reviewed by RN suphandwritten orders, were discovered in Licensed Practical I more specific and it were not signed by physician. The Regishe received the tell between 4 p.m. and that she had not trafform the PCP when On 9/30/09 at approviate the investigation, transcribe telephone b. Review of a physion, transcribe telephone b. Review of a physi	a readmission order that a readmission order that alid for 120 days. Resuming T.O. (telephone order) PCP pervisor 9/23/09." Additional dated September 23, 2009 the nurses' station by Nurse (LPN) #1 that were dentified discharge orders that the transcriber or the plater Nurse (RN) stated that tephone orders from the PCP 15 p.m. and acknowledged inscribed the telephone order it was given to her.  Eximately 3:30 p.m. contact PCP via phone which verified to e RN supervisor a telephone previous orders. At the time the facility's RN failed to e orders as given.  Ician order dated September sately 8:55 am revealed the e Dilantin chewable tablets a 2 tablets crushed via G tube for seizure disorder, hold tube efore and after administration and the corresponding tration Record at 9:00 a.m. ent was receiving her G-tube to 6 a.m.  Cation Administration Record vealed that the client was Dilantin chewable U-D 50 mg at 6 AM. In an interview	{W 3	31)		

PRINTED: 11/02/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NÓ. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R-C B. WING 096123 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE (X4) ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) (W 331) (W 331) Continued From page 21 acknowledge that Client #1 was administered Dilantin chewable U-D 50 mg 2 tablets, via G-tube at 6 a.m. Review of the Client #1's records at approximately 10:45 a.m. revealed a physician order, dated September 1, 2009. According to the physician's order, the client was prescribed Dilantin 2 tabs (100 mg) crushed via G-tube for selzure disorder. Review of the September 2009 MAR; however, documented the transcription of the order on September 29, 2009 as Dilantin (chewable)U-D 50 mg tab, 20 tablets (100 mg) crushed via G-tube for seizure disorder. The MAR was signed by a nurse on September 30, 2009 indicating the order for 20 tablets had been administered. Interview with the RN supervisor at approximately 10:45 a.m. acknowledge the order for 20 tablets of Dilantin crushed via G-tube for seizure disorder had been transcribed instead of Dilantin (chewable) U-D 50 mg tab, 2 tablets (100 mg) crushed via G-tube everyday. 2. The nursing staff failed to calculate Client #1's G-Tube flushes in accordance with physician orders which could likely pose a risk to the clients' health and safety as evidence by: Review of the Client #1's medical record revealed a physician order, dated September 1. 2009. According to the order, the client was to receive water flushes (via G-tube) prior to medications, between, and after medications. The order specified that her G-tube was to be

flushed with 20 cc of water both prior to and after medications, and a 5 ml flush was to occur between medications. The review of the corresponding Fluid Intake Monitoring Sheet for G-Tube, dated September, 2009, revealed that

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	HULTIP!	LE CONSTRUCTION	(X3) DATE COMP		
		09 <b>G</b> 12 <b>3</b>	B. WI			10	R-	C 3/2009
	ROVIDER OR SUPPLIER JAL DEVELOPMENT,	INC.		431	ET ADDRESS, CITY, STATE, ZIP CODE 1 53RD STREET, SE ASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE		(XS) COMPLETION DATE
	flushes, which did raf times medication Director of Nursing discrepancy.  Interview with the Dacknowledged that completed the flush 3. The nursing staff physician telephone could likely pose a safety as evidence a. Review of Client: telephone order, da According to the client was 30 cc/hr, 1 can ever (total of 3 cans per Procel a day or 909 of water a day ". To administer three restriction of one can 12 hour continuous failed to identify the Protein supplement client s continuous interview with the Diapproximately 5:30 cans of the Osmolytics.	inted completing 70 cc of water not correspond to the number was administered. The (DON) could not explain the director of Nursing at 5:30 p.m. the facility nursing staff were less incorrectly.  If alled to clarify Client #1's eorders accurately, which risk to the clients' health and by:  #1's records revealed a ted September 29, 2009. Bot's physician's telephone is prescribed "Osmolyte 1.2 at y 6 hours from 6 a.m 6 p.m. day) with 2 packages of keals, 49 gm protein, 580 ml he nurse failed to clarify how cans of feedings with the mevery six hours during her feed. Furthermore, the nurse exact type and amount of to be administered with the feed. It should be noted that frector of Nursing at p.m. acknowledged that three is 1.2 could not be left the prescribed rate within	{W 3	31)				
	and General Emerge	ient #1's medical records ency Department Discharge eptember 9, 2009 revealed "Primary Diagnosis:			·			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED <u>ОМВ NФ. 0938-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A, BUILDING B. WING 10/16/2009 09G123 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) (W 331) {W 331} Continued From page 23 Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiery Diagnosis: Complication-postoperative infection." The Emergency Discharge summary recommended Keflex 500 mg Twenty eight: one capsule every 6 hours for 7 days. Review of the physician telephone order dated September 9. 2009 revealed Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days for abscess. 4. The facility nurses failed to administer Client #1's prescribed G-tube feeding at scheduled time. On September 30, 2009 at approximately 6:00 p.m. Client #1 was observed laying in her bed. at approximately a 30 degree angle and was not receiving her 6 p.m. continuos G-tube feeding. At approximately 6:15 p.m., the Department of Health surveyors informed the Director of Residential Services that Client #1's prescribed feeding had not been administered at the prescribed time. At approximately 6:35 PM the LPN #2 was observed administering 2 cans Osmolite 1.2 cal at 30 cc/hr. 5. The facility nurses failed to update Client #1's Health Management Care Plan (HMCP). a. Review of the Client #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 on September 30, 2009 revealed that the client had "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis:

Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection."

Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUFPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R-C B. WING 10/16/2009 09G123 STREET ADDRESS, CITY, STATE, 2IP COOE NAME OF PROVIDER OR SUPPLIER 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (XS) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY (W 331) Continued From page 24 (W 331) approximately 1:00 a.m. revealed Client #1's HMCP did not updated to include the new diagnoses of Abscess/cellulitis-skin and postoperative infection. Interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:15 a.m. acknowledged that the HMCP had not been updated to include the September 9, 2009 Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection. b. Review of the hospital discharge summary report dated September 22, 2009 revealed that Client #1 was hospitalized from September 15, 2009 to September 23, 2009 for treatment of an elevated temperature and PEG tube infection. Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at approximately 1:05 a.m. revealed Client #1's HMCP was not updated to include the treatment for elevated temperature and PEG tube infection. Interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:35 a.m. acknowledged that the HMCP had not been updated to include the hospitalization for elevated temperature and PEG tube infection. There was no evidence that the HMCP had been updated since August 25, 2009. 6. The facility nurses failed to accurately implement Client #2 and #3's fluid restriction. Review of Clients #2 and #3's Fluid Restriction

Intake Sheets on September 30, 2009 at approximately 4:00 p.m. revealed inaccuracies

with the amounts of fluids received.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2009 FORM APPROVED OMB NO. 0938-0391

	CORRECTION	EDENTIFICATION NUMBER:	1''		PLE CONSTRUCTION '	COMP	LE	IRVEY TED
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		09G123	B. WII	NG _		10/	116	5/2009
	ovider or supplier Al development,	INC.	-	4	EET ADDRESS, CITY, STATE, ZIP CODE 31 63RD STREET, SE /ASHINGTON, DC 20019			
(X4) ID PRÉFIX TAG	(EACH DEFICIENC)	(TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	'IX	PROVIDER'S PLAN OF CORREC (EACH/CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE		COMPLETION DATE
{W 331}	Continued From pa	ge 25	{W 3	331}				
	supervisor on Sept approximately 10:0	eted with the facility RN ember 30, 2009 at 0 a.m. revealed that Cllent #2 uid restriction of 880 's cc of						
	client was prescribe of fluid daily. Revie utilized by nursing a Monitoring Sheet) a mealtime protocol)	I's physician orders verified the ed a fluid restriction of 880 color of the documentation staff (i.e. Fluid Intake and the direct care staff (i.e. at approximately 3: 40 p.m. I stotal allotted daily fluids 20 cc daily.			: :			
	September 30, 200 acknowledged, the sheet and mealtime	etor of Nursing (DON) on 9 at approximately 5:00 p.m. of luid intake documentation of protocol, were inaccurate not adhering to the 880cc of ibed.						
1	supervisor on Septe approximately 10:0	ted with the facility RN ember 30, 2009 at 0 a.m. revealed that Client #3 uid restriction of 1500 cc of						
	that the client was p 1500 cc of fluid dail							
	Fluid Intake Monitor staff (i.e. Mealtime !	red by the nursing staff (i.e. ring Sheet) and the direct care Protocol) at approximately the client's total allotted daily ad 1720.			·			
	nterview with Direc	tor of Nursing (DON) on			<u> </u>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 11/02/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	PLE CONSTRUCTION (X3) DATE COMP	ETED R-C
		09G123	B. WING		16/2009
4-,	ROVIDER OR SUPPLIER JAL DEVELOPMENT,	ING.	48	EET ADDRESS, CITY, STATE, ZIP CODE 31 53RD STREET, SE /ASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	acknowledged, the sheet and mealtim and the facility was fluid daily as preson there was no evid requirements were 483,460(c)(3)(iii) Nursing services in certified as not nearened as not nearened as not nearened as not nearened.  This STANDARD Based on interview of their head quarterly or more action to need.  This STANDARD Based on interview facility's registered direct physical exact quarterly or on a not he six clients resident #5)  The findings included the six clients resident #5)  The findings included the six clients resident #6)  The findings included the six clients resident #6)  The findings included the six clients resident in the six clients resident r	29 at approximately 5:10 p.m. a fluid intake documentation e protocol, were inaccurate a not adhering to the 1500cc of ribed.  The implemented as prescribed.  The implemented as prescribed.	(W 331)	W336  This Standard will be met as evidenced by:  1. The quarterly nursing assessment was completed for client #4.  2. Client #5's annual nursing assessment has been completed.  The RN assigned to each home will maintain a schedule of dates when quarterly reports and assessments are due. Schedules of completion dates will be performed within the month in which the end of the quarter falls. The Director of Nursing or designated consultants will review the records of a regular basis to ensure ongoing compliance. The Director of Nursing will review all Annual Nursing Assessments for new and incoming RN's to ensure that documents are completed in accordance to standard.	n I
]	2. Review of Clien	nt #5's medical record on		Completes in accordance to stalloald	.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/02/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA <u>OMB NO. 0938-0391</u> (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A BUILDING 8. WING 090123 R-C NAME OF PROVIDER OR SUPPLIER 10/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE INDIVIDUAL DEVELOPMENT, INC. 431 53RD STREET, SE Washington, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE TAG (X5) COMPLETION DATE TAG DEFICIENCY) W 336 Continued From page 27 WZEZ W 336 October 7, 2009, at approximately 7:00 p.m., revealed an annual nursing assessment dated This Standard will be met as September 27, 2009, however, the assessment was incomplete. The assessment had four of the evidenced by: seven pages completed. Interview with the RN on October 7, 2009, at approximately 5:00 p.m., 1. Disciplinary action was taken confirmed the assessment was incomplete. against the LPN staff who (W 368) 483.460(k)(1) DRUG ADMINISTRATION 11.18.09 (W 368) failed to administer The system for drug administration must assure ongoing medications in compliance that all drugs are administered in compliance with with the physician orders. the physician's orders. (#3,#4, and #6).The RN will review the records on a This STANDARD is not met as evidenced by: Based on observation, staff Interview and record regular basis, address review, the facility failed to ensure that all drugs discrepancies and ensure that were administered in compliance with the that there is documented physicians ' orders, for three of the six clients

The findings include:

1. The nursing staff failed to administer Client #4's order as prescribed which posed a likely risk to the client's health and safety.

residing in the facility, (Clients #3, #4 and #6)

a. Observation of the evening medication administration on October 7, 2009 at 6:45 p.m. revealed Client #4 was administered Novolog insulin, 5 units, Glucophage 1000 mg, and Os-Cal 200 mg. Review of the corresponding Medication Administration Record (MAR) and October 2009 physicians orders on October 7, 2009, revealed the client was prescribed Novolog insulin 5 units before dinner on October 7, 2009.

A face to face Interview with LPN #1on October 7, 2009 immediately following the medication

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Event ID: BTN812

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evidence reflected in the record that the primary care

Director been informed and

Reference response to #1.

provided direction as needed.

The LPN staff are expected to

review the MAR's q shift and

addition, the RN will review

MAR's and physician orders

and Shoulders is currently

being administered as

prescribed.

for accuracy. Client #4's Head

reconcile as needed. In

physician and Medical

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/02/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING R-C 09G123 NAME OF PROVIDER OR SUPPLIER 10/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE INDIVIDUAL DEVELOPMENT, INC. 431 SSRD STREET, SE WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG (XB) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY (W 368) Continued From page 28 (W 368) observation revealed that she gave Novolog W368, continued... insulin 4 units previously ordered on February 20, 2009. When LPN#1 was asked by the surveyor why she did not give the 5 units as ordered, she Reference responses to #1 and #2. stated "I was not aware of the new order". Further observation on October 7, 2009 at approximately 6:00 p.m. revealed the nurse changed on the MAR to indicate that Novolog 1 and 2. insulin 5 units would start on October 8, 2009 and not on October 7, 2009 as ordered by the Client #1 no longer resides in the physician. 10.H04 home. The staff assigned to client#1 received disciplinary action for failing mapmy There was no documented evidence in the record that the nurse made the physician aware that the to document and provide follow-up in order did not start on October 7, 2009 as accordance to policy and procedures prescribed. and nursing standards of practice. b. Review of Client #4's record on October 8, Additional training competency based 2009 at approximately 11:00 a.m. revealed a telephone order dated July 21, 2009, at 4:20 p.m. training was provided to the LPN staff The order the client was to receive which assigned to the home to include but documented, "Debrox ear drops 6.5% 5 drops to not limited to; medication both ears twice daily for five days (which should equal to 10 doses of medication) for wax administration, and compliance removal." physician orders, transcribing orders. Further review of the clients record revealed a MAR for July 2009 that documented that the facility's nursing staff failed to administer all ten doses of Debrox as ordered. According to the record, Client #4 received nine of the ten doses Reference responses to W331 and ordered. W192.

FORM CMS-2587(02-99) Previous Versions Obsolets

c. A record of Client #4's record on October 8, 2009, at approximately 11:30 a.m. revealed a telephone order for Debrox dated August 4, 2009 at 4:30 p.m. According to the order, the client was to receive "Debrox optic drops 6.5% instill 4 drops in left ear twice a day for 5 days (which

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Fecility ID: 09G129

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		FORM APPR OMB NO. 0938 (XS) DATE SURVEY	
		1	A BUILDII	NG	COMP	LETED
		09G123	B. WING		1	R-C
	PROVIDER OR SUPPLIER		1877	DEET ADDRESS AND ASSESSMENT OF THE PROPERTY OF	10/	16/2009
NDIVID	UAL DEVELOPMENT	, INC,	"	REET ADDRESS, CITY, STATE, ZIP CO 131 53RD STREET, SE	DE	
(X4) ID	SUMMARY ST	ATEMENT OF DEPICIENCIES	l V	VASHINGTON, DC 20019		
PREFIX TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	<b>A</b>	COMPLETA DATE
V 368}	Continued From pa	ige 29	(W 368)			
	should equal to 10	doses of medication)."	(44 308)			
	Further review of re August 2009 which nursing staff failed to	ecord revealed a MAR for documented that the facility to administer the ten doses of ent #4 received nine of the ten				
}	∠UUB,at approximate	#4's record on October 8, ely 3:00 p.m. revealed an 30, 2009 for "Head and		,		
	MAR'S from Februar which documented to of the Head and Sho	ent #4's record revealed y 2009 through October 2009 hat Client #4 had treatments judders three times a week ed dated from February 23,				
r ii k a ti	evealed that Client and January 2009 how coate the report at the cknowledged that C	interview with LPN#2 on approximately 4:55 p.m. 44 had a dermatology consult ever, she was unable to settline of the interview. She lient #4 was not receiving or treatments daily as				
in oi re dr	4, 2009, at 1:33 p.m. dicated that Client # rder for eye drops. Fedical records on Onvealed a telephone ops, four times a dactober 7, 2009 at 5:00	the registered nurse (RN)  3 received a new physician Review of Client #3's ctober 14, 2009 at 2:30 p.m. arder for Gentamicin eye y to both eyes, dated to p.m. According to the ed Gentamicin (generic eye				

TEMENT OF DEFICIENCIES	& MEDICAID SERVICES			FOR	M APPROV
PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIS A. BUILDING	PLE CONSTRUCTION	(XS) DATE	O. 0938-03 SURVEY LETED
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ME OF PROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP C	10/	16/2009
DIVIDUAL DEVELOPMENT,	<u> </u>	43	11 53RD STREET, SE ASHINGTON, DC 20019	ODE	
TAG REGULATORY OR LS	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE EAPPROPRIATE	COMPLETA DATE
October 14, 2009. If October 14, 2009 at confirmed the client a day.  There was no eviden medication nurse adi drops as ordered (for 3. Review of Client # October 8, 2009, at 4 telephone order dates was for Augmentin 50 for 15 days (30 doses medication administration of the client beginning on May 18, medication administration for 18, 2009 at aprevealed that the client beginning on May 18, medication administration for 18, 2009 at aprevealed that the client beginning on May 18, medication administration for the client received 27 dose medication.  Additionally the registed interviewed on Octobe 5:10 p.m., to ascertain location of the June 20 dld not retrieve the June 20 dld	ng October 9, 2009 through interview with the RN on approximately 3:00 p.m., received two eye drops twice ce that the facility's ministered Client #3's eye in times a day).  6's medical record on 1:15 p.m., revealed a day 18, 2009. The order 20 mg by mouth, twice a day 20 mg by mouth, twice a day 3). Review of the client's ation records (MARs) on a proximately 4:30 p.m. In treceived the medication 2009, during the evening ation through May 31, 2009. MARs revealed that the es of the prescribed ered nurse (RN) was are 8, 2009 at approximately information regarding the 109 MAR. The RN could be 2009 MARs. By the end alled to locate and provide	{W 368}	JET CHERCET)		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/02/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA MB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 09G123 R-C NAME OF PROVIDER OR SUPPLIER 10/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE INDIVIDUAL DEVELOPMENT, INC. 491 53RD STREET, SE WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (X5) COMPLETION DATE TAG (W 368) Continued From page 31 (W 368) three clients included in the sample. (Client # 1) The finding includes: 1. Review of the Client #1's medical records and General Emergency Department Discharge Instructions dated August 25, 2009 at 12 noon revealed that she was diagnosed with a Furuncle (boil). Further review of the medical record revealed a physician order, dated August 25, 2009. According to the physician 's order, Bactrim OS Suspension 20 ml was prescribed to be administered via G-tube twice a day for 7 days (for upper lip abscess). Although the medication was prescribed for 7 days, the August 2009 MAR indicated that Bactrim OS Suspension 20 ml was initially administered on August 26, 2009 at a.m. and discontinued on September 2, 2009 at 7 p.m. (8 days). Interview with the RN Supervisor at approximately 12:15 p.m. acknowledged that Bactrim OS Suspension 20 ml was prescribed to be administered via G-tube twice a day. Additionally, the RN verified that the medication had been administered for 8 days. 2. Review of the Client #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 revealed that the client had a "Primary Diagnosis: Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection." The Emergency Discharge summary recommended "Keflex 500 mg Twenty eight: one capsule every 6 hours for 7 days." Review of the physician telephone order dated September 9, 2009 revealed Keflex 250 mg/5 ml suspension 10 rni P.O. Q 6 hrs x 10 days for abscess.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BTN612

Facility ID: 09G123

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/02/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION DENTIFICATION NUMBER: A BUILDING R-C B. WING 09G123 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETION PREFIX TAG TAG DATE DEFICIENCY) (W 368) Continued From page 32 W 368) Review of September 2009 MAR on September 30, 2009 at approximately at 1:00 PM revealed Keflex 250 mg (5 ml suspension) 10 ml Q 6 hours x 10 days was not documented as administered on September 13, 2009 at 6 p.m. Interview with the RN Supervisor at approximately 1:15 p.m. acknowledged that Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs was not W381 documented as administered. W 381 483.460(I)(1) DRUG STORAGE AND W 381 This Standard will be met as RECORDKEEPING evidenced by: The facility must store drugs under proper conditions of security. The LPN assigned to the home received disciplinary action for failing ONCOM This STANDARD is not met as evidenced by: to secure the medication closet. The Based on observation and interview, the facility's LPN no longer works for the company. nurse failed to store drugs under the proper conditions of security, during the medication The RN will monitor and observe administration, for two of the six clients in the medication administration passes on a facility. (Clients #4 and #6) routine basis to include proper The findings include: security of medications. 1. On October 7, 2009 at 7:41 p.m., the licensed practical nurse (LPN) #1 was observed to leave the medication closet door opened and unlocked while she went to administer Client #4's medication in her bedroom. When the medication closet door was open; the direct care staff, clients, the Director of Residential Services (DRS), and surveyors were in the room while the medications were unsecured. The DRS was informed and acknowledged the unsecured medications at 7:45 p.m.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/02/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. SUILDING COMPLETED 09G123 B. WING R-C NAME OF PROVIDER OR SUPPLIER 10/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE INDIVIDUAL DEVELOPMENT, INC. 431 53RD STREET, SE WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FUL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X5) COMPLETION TAG DATE DEFICIENCY W 381 Continued From page 33 W 381 2. On October 14, 2009 at 7:58 p.m., LPN #1 was observed to leave the medication closet door opened and unlocked will she went to administer Client #6's medication in their bedroom. When the medication closet door was open; the direct care staff, clients, the Director of Residential Services (DRS), and surveyors were in the room while the medications were unsecured. The DRS was informed and acknowledged the unsecured medications at 8:07 p.m. {W 436} 483 470(g)(2) SPACE AND EQUIPMENT (W 436) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client, This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to furnish custom molded shoes, for one of the six clients residing in the facility. (Client #4) The finding includes: On October 7, 2009 and October 8, 2009, Cilent #4 was observed kicking off her sneakers. Interview with the direct care staff during the survey revealed that the client does not like to keep shoes on. Review of Client #4's medical record on October 8, 2009, at 1:45 p.m., revealed a podiatry consult dated September 11, 2009. The consult indicated mild discolorations on the 4th and 5th left toes, FORM CMS-2567(02-99) Pravious Versions Obsolete Event ID: BTN812 Facility ID: 09G123

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/02/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A BUILDING 09G123 B. WING R-C NAME OF PROVIDER OR SUPPLIER 10/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE INDIVIDUAL DEVELOPMENT, INC. 431 53RD STREET, SE WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/02/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY COMPLETED A. BUILDING R-C 09G123 B. WING NAME OF PROVIDER OR SUPPLIER 10/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE INDIVIDUAL DEVELOPMENT, INC. 431 53RD STREET, SE WASHINGTON, DC 20019 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION
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CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (X5) COMPLETION TAG TAG DATE DEFICIENCY) (W 436) Continued From page 35 (W 436) the home was currently utilizing the old chair scale, which was observed in the wheelchair bathroom located towards the nursing station. Interview conducted with the Qualified Mental Retardation Professional (QMRP) at approximately 9:30 a.m. revealed that a new scale (Detecto 6475 digital chair scale) was recommended by the Registered Dietitian (RD) on September 1, 2009 and ordered. The new scale would be shipped to the group home on October 2, 2009 and during the interim, the old chair scale would continue to be utilized. Documentation for the new scale ordered, however, was not available for verification at the time of the investigation. Interview with the Director of Nursing at 5:30 p.m. acknowledged that the facility had not acquired W455 the new scale. W 455 483.470(I)(1) INFECTION CONTROL W 455 This Standard will be met as evidenced by: There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Additional staff training has been completed on infection control and maintaining sanitary conditions and This STANDARD is not met as evidenced by: Based on observation, staff interview and record use of gloves and hand washing at all review, the facility failed to implement correct times. infection control procedures to prevent communicable infectious diseases, for one of the six clients residing in the facility. (Client #7) The Home Manager and nursing staff assigned to the home will continue to

FORM CMS-2567(02-99) Previous Versions Obsolete

The finding includes:

During dinner observations, on October 14, 2009

at 7:35 p.m., Client #7 was observed spitting chewed food onto the floor. The direct care staff

Event ID: 8TN612

Facility ID: 09(3123

standard.

monitor infection control practices to

ensure ongoing compliance with this

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTIED: 11/02/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING\_ 09G123 R-C NAME OF PROVIDER OR SUPPLIER 10/15/2009 STREET ADDRESS, CITY, STATE, ZIP CODE INDIVIDUAL DEVELOPMENT, INC. 431 63RD STREET, SE WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE PREFIX TAG DEFICIENCY) W 455 Continued From page 36 W 455 was observed wiping the food from the floor with paper towels. The staff was not observed to wear gloves or wash her hands after she wiped up the food from the floor. Although review of the staff in-service training book on October 15, 2009 confirmed that staff had received infection control training on the management of body fluids, the training was ineffective.

FORM CMS-2587(02-99) Previous Versions Obsolets

Event ID: BTN812

Facility ID: 09G123

If continuation sheet Page 37 of 37

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(1 000) INITIAL COMMENT	rs	(1	000)				
from DC Health Resconsultant with Depo (DDS) that indicated health and safety of facility. A nurse with Partnership (DCHRI deficient practices at 1. There was no Liquid or Registered Nurse 7:00 a.m. and 7:30 a pass medications an a.m. All scheduled must be supplied to the second supplied to the se	ertment on Disability of concerns related to a Resident residing in the DC Health Resord P) alleged observing a specified below:  Densed Practical Nurse (RN) in the home bear.  The LPN schedurived some time after nedication passes we as an insulin dependation her breakfast with the process of the LPN the blood sugar, with the knowing that she have besident's blood sugar of tified and ordered the	Services the n the urces systemic e (LPN) tween led to 8:00 re late; ent thout PN the ad been tread					
3. There were no lar to perform blood sug	ar finger sticks.	home		·			
<ol> <li>There was a noted resident's medical re- physician's order and record.</li> </ol>	cord between the writ	ten ration					
Due to the nature of the facility's status of being identified on September the State Survey Agent Investigation on October investigation, concern revealed the facility has	ng in immediate jeopa per 30, 2009) surveyo ncy (SA) initiated an o per 7, 2009. During the is were identified that	rs from ensite e					
Regulation Administration  WWW ATORY DIRECTOR'S OR PROVIDER	MUMM— VSUPPLIER REPRESENTAT	NE'S SIGNATUR		Diffe	C	(B) DATE/	

PRINTED: 11/02/2009 Health Regulation Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0035 NAME OF PROVIDER OR SUPPLIER 10/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE INDIVIDUAL DEVELOPMENT, INC. 431 53RD STREET, SE WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4):ID PROVIDER'S PLAN OF CORRECTION
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DEFICIENCY) PREFIX ID PREFIX (X5) COMPLETE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG [1 0000] Continued From page 1 {I 000} systems to remove the immediate jeopardy and therefore, Residents' health and safety continued to be at risk. On October 13, 2009 the SA received an allegation of compliance indicating that the Immediate jeopardy had been removed. However, observation and interviews on October 14, 2009 and October 15, 2009 revealed continued deficient practices existed related to the health and safety of the clients and the immediate jeopardy remained in effect. On October 16, 2009, the facility removed the immediate jeopardy by taking immediate and aggressive action to remedy the problems as evidenced by the following: a. LPN #1 was removed from work schedule and was to be scheduled to be terminated by October 19, 2009: b. RN #1 was removed from the work schedule pending further corrective action: c. The facility indicated that corrective would be implemented to address the DON's failure to supervise and provide adequate oversight of nursing care services. The findings of the survey were based on observations in the group home, interviews with the facility's management, nursing and direct care staff and the review of records, including unusual incident reports, Investigation reports and administrative records. Three clients with various disabilities were selected from a residential population of six females. (1 229) 3510.5(f) STAFF TRAINING (I 229)

Health Regulation Administration

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Health	Requiation Administra	ation			:	FOF	M APPROVE
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t e to a 2 to DO	Each training progral limited to, the following residents to be served to, behavior manage recreation, total complete to the complete complete to the complete comple	im shall include, but ing:  elated to the GHMRF and including, but not sment, sexuality, nutimunications, and as net as evidenced by:  n, interview and recome for Mentally Retailed to ensure staff orders correctly and tocols were implemedents residing in the color of the GHMRP submit DC) to address defice October 1, 2009 substitutional training on with mealtime protocan orders, and nutrities an orders, and nutrities an orders orders.  The GHMRP fallers effectively trained physician's orders.	and the limited rition, sistive ord arded were failed to ented, facility.	{1 229}	3510.5 (f)  This Statute will be met as evidenced by:  1. Cross reference responses to Wand W192.  3. Reference response to W2.  4. Reference response to W2.  Reference response to W3.  1. Reference response to W3.  2. Reference response to W3.  Also reference responses to W4.  Also reference responses to W4.  Also reference responses to W4.  W149, W368, W381, W436, and W455.	/331 192. 192 136. 192. 10	11.18.09 Orgoniz
	on Administration						

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	OF CORRECTION	IDENTIFICATION NU	mber;	A. BUILDING B. WING	LE CONSTRUCTION	- COM	SURVEY PLETED R	
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	Practical Nurse (LP administering Residual regular cup. The from the client's moobservations on Octobe direct care staff client with drinking uobservations reveal meal. Interview with	N) was observed lent #5 her medication liquid was observed at the During dinner tober 14, 2009, at 5:3 was observed assist using a spout cup. Fused no spillage during the direct care staff uring the meal indicated april 22, 2009, we avealing the resident at April 22, 2009, we avealing the resident at Failed to demonstrate and regular thing the resident #5 and Reference and regular thing the client with the meal observations as heard gurgling. The dears and regular thing the client with the meal observations as heard gurgling. The dears and regular thing the client with the meal observations as heard gurgling. The dears and regular thing the client with the meal observations as heard gurgling. The staff was consistency of Resident at a consistency of Resident care care stated that all liquids were stated that all liquids were	to spill 35 p.m., ing the inther the on sted that eding to #5's rified the should ice trate is sident 7, e direct t #5 her key n liquid at 7:38 ie direct b was ient h was ient hat the	(1 229)				

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	The resident's curre October 2009, confiliquid consistency. It should be noted the training records on approximately 3:00 care staff received the feeding protocol on direct care staff faile nectar thickened liquids.  4. On October 7, 200 was observed eating of shredded chicken interview with the direct meal, indicated that it texture diet.  Review of Resident if January 22, 2009, rediet. Further review ophysician orders date the mealtime protocological.	ent physician orders of irmed the review of the October 8, 2009, at p.m., revealed that it raining on Resident: August 28, 2009; hold to provide the projuid consistency to Resident. The meal of sliced carrots and rect care staff, during the client receives a f4's mealtime protocyealed a chopped te of the resident's curred October 2009, corel.	kened facility's ne direct #5's wever the per esident ident #4 consisted ice. I the chopped oi dated xture ent infirmed	{  229}	DEFICIE	NCY	
F	Review of the facility! October 8, 2009, at a revealed that the staf Resident #4's diet and 28, 2009. However the proper die the during meals.	pproximately 3:00 p. freceived training or d feeding protocol or the direct care staff for	m., 1 1 August 1 August				
_ la	lased on interview en alled to ensure that e ursing services was to on Administration	<b>ach emplovee</b> provid	lina i				
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INDIVID	UAL DEVELOPMENT,		431 53RD Washing	STREET, SE TON, DC 20	<b>!</b> .			
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{I 229}	Continued From pag transcribe orders, as	_		(1 229)				
	administer G-tube for likely harm to all res	edings. This failure	posed		:			
	The findings include	<b>):</b>			:			
	1. The facility's nurs that each licensed at procedures to accura body weight.	iert heviesen böd fils	ning on I		:			
	Resident #1 had a of from 88.7 pounds in April 2009. The client had lost an additional her Healthy Weight R. On September 30, 20 interviews were conditioned information. According to a complete the clients in was suspected that we completed and/or measure accidentify measures to edirector of Nursing (Disupervisory nursing state of the clients in the condition of the clients and the weight variations and the weight variations. The condition of the condition and the condition of	March 2009 to 62 pot, as of September 2 I pound, placing her lange (HWR 62-82 II 2009, beginning at 8:4 ucted with the RN for of Nursing to ascepting to RN Superbeen documented for RN supervisor furtigating policy had been decurately in the RN supervisor furtigating policy had been decurated in the RN supervisor furtigating policy had been decurated if warranted. To N) revealed that the taff had provided traits correct policy and ang clients' body weight e scale to ensure the	punds in 9, 2009, below bs).  5 p.m., prtain visor, pr and it to he e ning to ante to					
re ha	arlier interview with the eptember 30, 2009 recommended by the land been ordered, but	Pealed that a new sonterdisciplinary Team	cale,					
ith Regulation TE FORM	n Administration		***	BTN6	2	# conti		

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PRINTED: 11/02/2008 Health Regulation Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING. HFD03-0035 10/16/2009 HAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4):ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PREFIX (XS) COMPLETE TAG DEFICIENCY  $\{1229\}$ Continued From page 6 (1 229) The QMRP indicated that the scale currently being used in the facility had been calibrated and was accurate. The QMRP also indicated that all nurses had been trained in its use. When the LPN on duty was asked to demonstrate the weighting techniques, she falled to following the weighing protocol that required the scale to be calibrated prior to placing the individual on the scale. The QMRP acknowledged that the LPN failed to following the weighing protocol. The RN was asked to provide evidenced that all nurses had been trained to weigh clients using the chair scale. The RN could not provide any documentation of training. 2. Similarly, interview with the nurses indicated that the Supervisory RN and Director of Nursing had trained nursing staff on tube feeding procedures for Resident #1. This reportedly addressed changes in the client's tube feeding schedule. Although it was stated that nurse training records would be documented in the in-service training book, subsequent review of the training records failed to show evidence of said training on tube feeding procedures. No additional information was provided; therefore, a chronological history of nurse training on the facility's weighing and G-Tube feeding protocol could not be verified. It should be noted that this is a repeat deficiency. 3. Cross Refer to W331 (#1a.b.c). The facility failed to ensure nursing staff were effectively trained to transcribe physician's orders accurately. a. Review of Resident #1's record on September 30, 2009 evidenced physician orders (dated Health Regulation Administration STATE FORM

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CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) (1229)Continued From page 7 (1 229) September 1, 2009, and September 9, 2009. September 23, 2009 September 29, 2009) that were transcribed inaccurately, which could likely posed a risk to the residents' health and safety. According to the Director of Nursing (DON), the supervisory nursing staff had provided training to all nursing staff on and after the August 25, 2009. on the importance of transcribing physician orders' accurately. Review of the in-service training records, however, failed to show evidence of said training on transcribing of all physicians' orders. The DON acknowledged that the physician's orders were transcribed incorrectly and that nursing inservice training session were ineffective. 3. Cross-refer to W331.6 The facility's nursing services failed to ensure that each licensed staff had received training on procedures to properly calculate fluid restrictions for Resident #2 and #3. as ordered by the Primary Care Physician (PCP), Review of Resident #2 and #3's Fluid Restriction intake Sheets on September 30, 2009 at approximately 4:00 p.m. revealed inaccuracles with the amounts of fluids received. a. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Resident #2 was prescribed a fluid restriction of 880 's co of fluid daily. Review of Resident #2's physician orders verified the client was prescribed a fluid restriction of 880 ec of fluid daily. Review of the documentation utilized by nursing staff ( i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e.

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PRINTED: 11/02/2009 Health Regulation Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0035 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X6) COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)  $\{1229\}$ Continued From page 8 [1229] mealtime protocol) at approximately 3: 40 p.m. revealed the resident's total allotted daily fluids intake measured 920 cc daily. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:00 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 880cc of fluid daily as prescribed. b. Interview conducted with the facility RN supervisor on September 30, 2009 at approximately 10:00 a.m. revealed that Resident #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Resident #3's physician 's orders, verified that the client was prescribed a fluid restriction of 1500 cc of fluid daily. Review of the documentation utilized by the nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. Meaitime Protocol) at approximately 3:45 p.m. revealed the client 's total allotted daily fluid intake measured 1720. Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:10 p.m. acknowledged the fluid intake documentation sheet and mealtime protocol were inaccurate and the facility was not adhering to the 1500cc of fluid daily as prescribed. Although it was stated that nurse training records would be documented in the in-service training book, subsequent review of the training records

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intake/restrictions

failed to show evidence of said training on fluid

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{! 291}	3514.2 RESIDENT	RECORDS		{I 291}	·		
	Each record shall be signed by each individual signed by each individual signed by each individual signed on interview: Home for Mentally Registed to ensure that records were signed residing in the facility. The findings include:  The GHMRP failed telephone orders we 24 hours as required Subtitle D, Chapter 1 a. Review of Resider telephone orders dat According to the order telephone orders dat According to the order revealed no evisigned by the primary interview with the regulatory of the primary interview with the regulatory of the primary of the signed of the telephone interview of Residen evealed a telephone 19, 2009. The order in the forehead with persintment every shift up if the telephone order of the telephone order of the telephone order of the telephone order of the telephone order or the telephone order of the telephone order or the telephone order or the telephone order of the telephone order or the telephone order order or the telephone order order or the telephone order or the telephone order or the telephone order order or the telephone order order order or the telephone order or	e kept current, dated vidual who makes an met as evidenced by and record review, the ctarded Person's (Gall entries in resident, for three of the six y. (Residents #4, #5 to ensure that physic re signed and dated by local regulation [13].  In #5's records revealed September 29, 20 ers, the Resident was ye drops to both eats of the review of the teldence that the order y care physician (PCI istered nurse (RN) of the person orders should be a PCP.  It #4's medical record orders dated September 29, 20 proving the person orders dated September 20, "Cleanse scratt oxide, apply Neospointil healed." Further revealed no evident orders revealed no evident orders and person orders and person orders or evident or evident orders or evident orders or evident or evident orders or evident or evident orders	entry.  le Group HMRP) ts' residents and #6)  lian's within Title 7,  led a 209. s liephone was P). in Tilesigned  is niber ch on review		This Statute will be met as evidenced by:  Reference responses to W: W114, and W149, and W4:	104,	11.19.199 17.19.199
П	he order was signed hysician (PCP). Inte urse (RN) on Octobe on Administration	IVIOW With the registe	ared i				

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NAME OF	ROVIDER OR SUPPLIER	111 100-0005	STOCET AD	DUEDO AITO		10	0/16/2009	
	UAL DEVELOPMENT,	INC.	431 53RD	STREET, S ITON, DC 2	STATE, ZIP CODE E CO19	-	-	
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	2:00 p.m. indicated be signed within 24 c. Review of Residerevealed a telephone 2009 at approximate the orders, the residered revealed a telephone order was signed by (PCP). Interview within 24 hours by the discontinue 17 units at bedtime for diabet units SQ at bedtime discontinue 1/2 diet punces apple juice Further review of the evidence that the orderimary care physicial registered nurse (RN approximately 4:00 porders should be signed.  Review of Residered that the orderimary care physicial registered nurse (RN approximately 4:00 porders should be signed.  Review of Residered that the orderimant of the signed but not discumented below:  On September 9, 20 redered via telephone	that telephone order hours by the PCP.  ent #4's medical recorder dated Octobely 3:15 p.m. Accordent was prescribed for mouth, every week of experience in the primary care physician at approximately 4:00 one orders should be the PCP.  Int #4's medical recorder orders dated Octobely 3:15 p.m. The order and the primary care physician orders dated Octobely 3:15 p.m. The order orders dated Octobely 3:15 p.m. The order diabetes mellitus; Given Lantus subcutaneous tes mellitus; Given Lan	s should  rd per 8, ling to Fosamax n eview of e that the evician se (RN) D p.m. e signed  der 10, ler read sity (SQ) antus 10 and and give acker. ealed no evith the extern exte	{1 291}	DEFICIENCY			
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If continuation sheet 11 of 33

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	er/CLIA MBER;	(X2) MULTI	PLE CONSTRUCTION G	(X3) DA GO	TE S	URVEY
		HFD03-0035		B. WING_				7
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	ITATE, ZIP CODE		0/7	6/2009
INDIVID	JAL DEVELOPMENT,		431 53RD STREET, SE WASHINGTON, DC 20019					
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	- On September 11, order to get pain me to pain 4th and 5th to finder, three times with normal saline.  Based on Interview as a led to ensure that a ecords were signed, neluded in the sample the findings include:	ation; the podiatrist wrote om made shoes; and 2009, the podiatrist edication from PCP in toes left foot.  ant #6's physician ord 2009 at 3:45 p.m., in inders that had been a facility's PCP as documented that had been at 1:00 p.m., the PCP continue Tylenol 650 a greater than 100. Shouth every four hour greater than 100 degreater than 100 degreater than 100 degreater than 100 may be at 1:00 p.m., the PCP e, Augmentin 500 may be at 1:	an order wrote an ordered signed sumented ordered mg start incee specially	{I 291}				
3	teview of the physicial september 30, 2009 a evealed Resident #1	St approximately 1·16	PM I					

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	Primary Care Physibelow:  On August 31, 2009 via telephone the cliprogram after an illn  On September 1, 20 via telephone to discochr x 10 hours from  On September 1, 20 telephone that the cliptocc 1 hour x 10 hours from the cliptocc 1 hours from the	it not dated by the faction (PCP) as documed at 5 p.m. the PCP or lent to return to her dates;  2009 at 3 p.m. the PCP continue Peptamen D m 7 p.m. until 5 a.m.;  2009 at 3 p.m. PCP or lent Start Peptamen is purs from 7 p.m. until egister Nurse on Seption of explanation.	ented  rdered  rdered  T @ 40  and  lered via  DT @  5 a.m.  ember	(1 291)			
{  401}	3520.3 PROFESSIO PROVISIONS Professional services and evaluation, include velopmental levels services, and service deterioration or further esident.  This Statute is not maked and on observation eview, the Group Hopersons (GHMRP) factorioes in accordance and coordance are reviews in accordance and coordance are reviews in accordance and coordance are reviews in accordance are reviews.	s and needs, treatmer as designed to preven ar loss of function by the net as evidenced by; in, interview and recommes for Mentally Retailed to ensure nursing be with each resident!	RAL (I	401}	3520.3  This Statute will be met as evidence by:  1. Reference response to W192 2. Reference response to W436 3. Reference responses to W193 W436 and 331.		16269 ongon

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PRINTED: 11/02/2009 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY: AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0035 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) [I 401] Continued From page 13 {1401} October 1, 2009, the GHMRP was cited for failure to ensure employees providing nursing serves. were trained to competently transcribe orders. assess weights, calculate fluid restriction and administer G-tube feedings On October 13. 2009, the facility submitted a Plan of Correction (POC) which stated that all nurses in the home would receive additional training on appropriate transcribing of physicians' orders, adherence to the medication administration policy, documentation and communication between the primary care physician (PCP), ensure consistency with mealtime protocols in accordance to physician orders and addressing nutrition recommendations. 1. Cross Refer to W192. The GHMRP failed to ensure nursing staff were effectively trained to transcribe and review physician's orders accurately. (Resident #4 and resident #5) 2. Cross Refer to W436. The GHMRP nurses failed to follow-up on medical consultation order for custom molded shoes for Resident #4. 3. The GHMRP's medication nurse failed to use the appropriate adaptive feeding equipment during medication administration for Resident #5. During medication administration observation on October 14, 2009 at 9:15 p.m., the Licensed Practical Nurse (LPN) was observed administering Resident #5 her medications using a regular cup. The liquid was observed to spill from the resident's mouth. During dinner observations on October 14, 2009 at 5:35 p.m., the direct care staff was observed assisting the resident with drinking using a spout cup. Further observations revealed no spillage during the

Health Regulation Administration

meal. Interview with the direct care staff on

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ME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		V16/2009
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1401}	Continued From page 14		{1 401}				
	October 14, 2009, of the resident required to reduce spillage. feeding protocol dat staff's interview by a be fed with an adapt spillage.	d a spout cup dur Review of the res ed April 22, 2009 evealing the resid	ring feeding sident #5's verified the				
	<ol> <li>During dinner obta 2009 at 6:33 p.m., R eating. The meal co sliced carrots and rid care staff, during the resident receives a c</li> </ol>	lesident #4 was onsisted of shredo > Interview with meal, indicated t	bserved ded chicken, the direct that the				
	Review of Resident i January 22, 2009, re diet. Further review o physician orders date the mealtime protoco	vealed a chopper of the resident's c ed October 2009.	d texture				
	Review of the facility' October 8, 2009, at a 'evealed that the staf Resident #4's diet and 88, 2009. However the Provide the proper die 14.	pproximately 3:00 freceived training of feeding protocological freeding protocological freeding protocological freeding protocological freeding fre	0 p.m., g on on August ff failed to				
v e n	dased on observation erification, the facility stablish systems to phonitoring and identifith residents' needs, the sample. (Resident #3)	r's nursing service provide health car y services in acco for three of three	es failed to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0035		(X2) MULTI A. BUILDING B. WING		(X3) DATE COMP	SURVEY LETED
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1. The nursing staff in #1's physician's order likely pose a risk to the evidence by the followard likely pose a risk to the evidence by the followard likely pose a risk to the evidence by the followard likely pose a risk to the evidence by the followard likely pose a risk to the evidence by the followard likely likely provided the proposition of the resident in the resident in the likely li	failed to transcribe fers accurately, which he residents' health wing:  nursing supervisor of at 8:45 a.m. reveals pitalized from Septialized that the RN similarly Care Physicials for 120 days. Resident of 120 days. Resident of 120 days. Resident September 23, enurses' station by 1738 (LPN) #1 that wentified discharge order transcriber or the ter Nurse (RN) station orders from the p.m. and acknowle transcribed the telephonewas given to her.  The properties of the september 3:30 p.m. cooperisor a telephonewas given to her.  The properties of the september 3:30 p.m. cooperisor a telephonewas given to her.  The facility's RN failed orders as given.	Resident the could as on ed that ember or ection. Upervisor and corders". ximately that suming r) PCP distinal and that he PCP dged e order estimated that he PCP dged estimated that he PCP d	{1 401}			

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	(U-D 50 mg tablets) everyday at 7 a.m. if feeding for 1 hour by of Phenytoin. Review Medication Administravealed that the research that the research feeding from Review of the Medication Administravealed that the research feeding from Review of the Medication feeding administered 12 tablets, via G-tube with the RN Supervisecknowledge that Redilantin chewable UG-tube at 6 a.m.  c. Review of the Research feeding from the Research feeding from the Research feeding from the Research feeding from the physician's order Dilantin 2 tabs (100 research feeding from the order on Septemble order on Septemble from the research feeding from the feeding from	o, 2 tablets crushed version seizure disorder, efore and after admits wo of the corresponding that on Record at 9:0 sident was receiving to 6 p.m. to 6 a.m. cation Administration vealed that the resident in chewable Use at 6 AM. In an intesor at 9:05 a.m., she esident #1 was admits both the resident #1 was admits both the resident #1 was admits both the resident was proposed in the resident	ia G tube hold tube nistration ing 0 a.m. her  Record ent was -D 50 mg rview enistered via sician ing to escribed be for er 2009 otion of intin	{I 401}			
	(chewable)U-D 50 morushed via G-tube for MAR was signed by a 2009 indicating the oradministered. Intervial approximately 10:45 for 20 tablets of Dilante disorder had library or ushed via G-tuit. The nursing staff for 1's G-Tube flushes obysician orders which a residents' health a con Administration.	or seizure disorder.  a nurse on Septemberder for 20 tablets ha ew with the RN superal.  a.m. acknowledge the sean transcribed inside the everyday.  alled to calculate Re in accordance with the could likely pose a	The er 30, ad been prisor at the order be for tead of ets (100 sident				

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AND PLAN OF CORRECTION  AND PROVIDER OR SUPPLIER  INDIVIOUAL DEVELOPMENT, INC.  STREET ADDRESS, CITY, STATE JUP CODE  431 SARD STREET, 3g.  WASHINSTON, DC 20019  PROPER  TAG  CONTINUED FOR THE PROVIDER OF PROVIDER PLAN OF CORRECTIVE CONTINUED BY PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY AND PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY AND PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY AND PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY AND PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY AND PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY AND PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY AND PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY AND PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY AND PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY AND PROPER PLAN OF CORRECTIVE ACTION SHOULD BE CONTINUED BY AND PROPER PLAN OF CORRECTIVE BY AND PROPER PLAN OF CORRECTIV	Health F	Regulation Administra	<u>ation</u>				FOR	M APPROVED
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(EACH COPICIENT MIST BE PRECEDED BY FULL TAG  Continued From page 17  Review of the Resident #1's medical record revealed a physician order, the resident was to receive water flushes (via G-tube) prior to medications, between, and after medications. The order specified that her G-tube was to be flushed with 20 cc of water both prior to and after medications, and a 5 ml flush was to occur between medications. The order specified that her G-tube was to be flushed with 20 cc of water both prior to and after medications, and a 5 ml flush was to occur between medications. The review of the corresponding Fluid intake Monitoring Sheet for G-Tube, dated September 2,009, revealed that the nurses documented completing 70 cc of water flushes, which did not correspond to the number of times medication was administered. The Director of Nursing (DON) could not explain the discrepancy.  Interview with the Director of Nursing at 5:30 p.m. acknowledged that the facility nursing staff were completed the flushes incorrectly.  3. The nursing staff failed to clarify Resident #1's physician telephone orders accurately, which could likely pose a risk to the residents' health and safety as evidence by:  a. Review of Resident #1's records revealed a telephone order, dated September 29, 2009. According to the resident's physician's telephone order, the resident's physician's telephone order, the resident's physician's telephone order, the resident's phouse form 6 a.m. 6 p.m. (total of 3 cans per day) with 2 packages of Procel a day or 909 kcals, 49 gm protein, 500 ml of water a day ". The nurse failed to clarify how to administer three cans or feedings with the restriction of one can every six hours during her 12 hour continuous feed. Furthermore, the			INC.	431 53RD	STREET,	SE		
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aith Regulation Administration		Review of the Resirevealed a physician 2009. According to receive water flushed medications, between The order specified flushed with 20 cc or medications, and a setween medication corresponding Fluid G-Tube, dated Septithe nurses document water flushes, which number of times medication the Director of Nurses the discrepancy.  Interview with the Director of Nurses the discrepancy.  Interview of Resident conduction of Resident water a service order, the resident water and	dent #1's medical ren order, dated Septer the order, the reside is (via G-tube) prior the ren and after medical that her G-tube was f water both prior to it is made in the fact that her G-tube was f water both prior to it is. The review of the intake Monitoring Silember, 2009, revealed completing 70 cm did not correspond it dication was administing (DON) could not rector of Nursing at She facility nursing states incorrectly.  Tailed to clarify Resident orders accurately, whick to the residents' ce by:  In #1's records revealed September 29, 20 dent's physician's teas prescribed "Osmis per day) with 2 pace of seeds, 49 gm proteins per day) with 2 pace of seeds, 49 gm proteins per day, who is to come cans of feedings were seed. Furthermore, the complete of the exact type and the complete of the exact type and the complete of the exact type and the corrections.	mber 1, ont was to be stions. to be and after cursed that c of to the stered, explain 5:30 p.m. off were ent #1's hich health led a lephone lolyte 6 a.m ckages in, 580 clarify with the lag her he amount	(1 401)			

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	resident's continuous that interview with the approximately 5:30 cans of the Osmoly administered in total the specified 12 hours of the Review	us feed. It should be the Director of Nursin p.m. acknowledged to 1.2 could not be at the prescribed raur feeding cycle.  Itesident #1's medical tency Department Disteptember 9, 2009 red a "Primary Diagnostite, status post surge is: Abscess/cellulitis-Complication-postopergency Discharge stax 500 mg Twenty eights for 7 days. Review order dated Septemex 250 mg/5 ml suspend days for abscess.  It failed to administer ribed G-tube feeding to 1009 at approximately as observed laying in 30 degree angle and continuos G-tube feeding that Resident #1's and not been administer of that Resident #1's and not been administer and reved administering the cover administer administe	g at that three at within all records scharge syealed sis: ery; skin and erative ammary ght: one of the aber 9, ension 10 or at the start of the sta	{  401}			
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PATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (A) PLAN OF CORRECTION  (B) PROVIDER OR SUPPLIER  (B) SUMMARY STATEMENT OF DEPICIENCIES  (B) CARD OF CORRECTION  (B) CARD OF CORRECTION  (CA) ID CARD	Health F	Regulation Administra	ation				FOR	IM APPROVED
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INDIVIDUAL DEVELOPMENT, INC.  431 SSRD STREET. SE WASHINGTON, DC 20019  SUMMARY STATEMENT OF DEPOLIENCIES.  (EACH DEPOLINCY MUST BE PRECEDED BY PULL TAG  CACH DEPOLINCY MUST BE PRECEDED BY PULL TAG  (I 401)  Continued From page 19  a. Review of the Resident #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 on September 30, 2009 revealed that the resident had "Primary Diagnosis: Callulitis-drianage site, status post surgery. Secondary Diagnosis:  Complication-postoperative infection."  Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at approximately 1:03 cm. revealed Resident #1's HMCP did not updated to include the new diagnoses of Abscess/cellulitis-drianage site, status post surgery. Secondary Diagnosis:  Abscess/cellulitia-skin and postoperative infection.  Review of the hospital discharge sammary report dated September 22, 2008 revealed that the HMCP had not been updated to include the September 3, 2009 Cellulitia-drianage site, status post surgery. Secondary Diagnosis:  Abscess/cellulitia-drianage site, status post surgery. Secondary Diagnosis:  Complication-postoperative infection.  b. Review of the hospital discharge summary report dated September 22, 2008 for treatment of an elevated temperature and PEG tube infection.  Review of the Health Management Care Plan dated October 22, 2009 on October 1, 2009 at approximately 1:05 a.m. revealed Resident #1's HMCP was not updated to include the treatment for clevated temperature and PEG tube infection, interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:05 a.m. acknowledged that the HMCP had not been updated to include the resident #1's HMCP was not updated to include the reatment for clevated temperature and PEG tube infection, interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:05 a.m. acknowledged that the HMCP had not been updated to include the resident #1's HMCP was not updated to include the sevated	NAME OF F	ROVIDER OR SUPPLIER		STREET AC	ADBESS CITY	STATE ZIP CODE	1	V10/2009
RECK   CORRECTIVE ADTION AND THE PRECEDED BY FULL		WASHIN		431 53RE	STREET. S	· · · · · · · · · · · · · · · · · · ·		
a. Review of the Resident #1's medical records and General Emergency Department Discharge Instructions dated September 9, 2009 on September 30, 2009 revealed that the resident had "Primary Diagnosis: Callulitis-chrainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection."  Review of the Health Management Care Plan dated October 22, 2006 on October 1, 2009 at approximately 1:00 a.m. revealed Resident #1's HMCP did not updated to Include the new diagnoses of Abscess/cellulitis-skin and postoperative infection. Interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:15 a.m. acknowledged that the HMCP had not been updated to include the September 9, 2009 Cellulitis-drainage site, status post surgery; Secondary Diagnosis: Abscess/cellulitis-skin and Tertiary Diagnosis: Complication-postoperative infection.  b. Review of the hospital discharge summary report dated September 22, 2009 revealed that Resident #1 was hospitatized from September 15, 2009 to September 23, 2009 for treatment of an elevated temperature and PEG tube infection.  Review of the Health Management Care Plan dated October 22, 2008 on October 1, 2009 at approximately 1:05 a.m. revealed Resident #1's HMCP was not updated to include the treatment for clevated temperature and PEG tube infection, interview conducted with the Director of Nursing on October 1, 2009 at approximately 1:05 a.m. acknowledged that the HMCP had not been updated to include the resident and peace and	PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETE
temperature and PEG tube infection.		a. Review of the Reand General Emerginstructions dated September 30, 2000 had "Primary Diagn status post surgery; Abscess/cellulitis-si Complication-postor Review of the Health dated October 22, 2 approximately 1:00 HMCP did not updated diagnoses of Absce postoperative infection the Director of Nursiapproximately 1:16: HMCP had not been September 9, 2009 status post surgery; Abscess/cellulitis-sk Complication-postop b. Review of the hos report dated Septem Resident #1 was hos 15, 2009 to September 3, 2009 to	esident #1's medical percy Department Diseptember 9, 2009 on 9 revealed that the recosts: Cellulitis-drainal Secondary Diagnoskin and Tertiary Diagnoskin and Tertiary Diagnostin and Tertiary Diagnostited to Include the new self-cellulitis-skin and ion. Interview conducting on October 1, 20 a.m. acknowledged to include the new self-cellulitis-drainage since and Tertiary Diagnostin and Tertiary Diagnostin and Tertiary Diagnostin and Tertiary Diagnostin and Tertiary Diagnostic in and Tertiary Diagnostic i	scharge n esident age site, age site	{  401}			

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0035		ER/CLIA MBER;	(X2) MUU A. BUILDI B. WING		COM	SURVEY LETED
NAME OF S				DBECC OITY	, STATE, ZIP CODE	10	/16/2009
	JAL DEVELOPMENT,	INC.	431 58RD	STREET, STON, DC	SE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	There was no evide updated since Augusticated since Augusticated Since Augusticated Since Augusticated Since Augusticated Since Augusticated Since September 30 and Since Sinc	ence that the HMCP   ust 25, 2009.  Is falled to accurately it #2 and #3's fluid re- i#2 and #3's Fluid Re- ieptember 30, 2009 a p.m. revealed inaccu- fluids received.  Ited with the facility Re- iember 30, 2009 at D a.m. revealed that I iefluid restriction of 8i iefluid restri	striction. estriction estriction est uracies  N Resident 80 ' s cc s verified ction of i.e. Fluid eare staff 3: 40 daily  on 00 p.m. Itation urate 80cc of	{  401}			
	tion Administration	FYOMIGH 5 010	J. 5,				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED	
l		HFD03-0035		B. WING		1 1	R 1 <b>6/2009</b>	
NAME OF P	ROMDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 1911	W-500	
INDIVIDU	IAL DEVELOPMENT,	INC.		STREET, S TON, DC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETE DATE	
{  401}	Continued From pa	ge 21		{  401}				
	verified that the resident was prescribed a fluid restriction of 1500 cc of fluid daily. Review of the documentation utilized by the nursing staff (i.e. Fluid Intake Monitoring Sheet) and the direct care staff (i.e. Mealtime Protocol) at approximately 3:45 p.m. revealed the resident's total allotted daily fluid intake measured 1720.  Interview with Director of Nursing (DON) on September 30, 2009 at approximately 5:10 p.m. acknowledged, the fluid intake documentation sheet and mealtime protocol, were inaccurate and the facility was not adhering to the 1500cc of fluid daily as prescribed.  There was no evidence that fluid restriction requirements were implemented as prescribed.							
i 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS  Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter.  This Statute is not met as evidenced by:		1 407					
	Based on interview and record review, the Group Home for Mentally Retarded Person's (GHMRP) registered nurse (RN) failed to ensure direct physical examinations were conducted quarterly or on a more frequent basis, for two of the six residents residing in the facility. (Resident #4 and #5)  The findings include:  1. Review of Resident #4's medical record on October 7, 2009, at approximately 4:00 p.m., revealed an annual nursing assessment dated							
	revealed an annual i	nursing assessment	dated					

Health f	Regulation Administra	ation				rora	M APPROVED
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0035			(X2) MULT A. BUILDI B. WING			LETED R
NAME OF E	PROVIDER OR SUPPLIER	711 200 0000	STREET AD	DESS CITY	STATE, ZIP CODE	10	16/2009
	UAL DEVELOPMENT,	INC.	431 53RD	STREET,	SE .		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI GROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD 86	(X5) COMPLETE DATE
	January 17, 2009. resident's record re-assessment in the rassessment. Interv 2009, at approximal direct physical examevery quarter (3 molecular 2. Review of Reside October 7, 2009, at revealed an annual September 27, 2009 was incomplete. The seven pages complete on October 7, 2009.	Further review of the vealed there was no record after the annuited with the RN on Cately 4:45 p.m., reveal innations should be conths).  ent #5's medical recompositions assessment 7:00 p. nursing assessment as feeted. Interview with at approximately 5:0 issment was incompleted. Interview with at approximately 5:0 issment was incompleted. Interview with the attaining of residents e, when appropriate, owing areas:  Iding skills related to stration of medication prosthetic and orthorhealth care, and safe the assessment received and record review an	quarterly all nursing october 7, led that completed ord on co.m., dated asment our of the the RN 00 p.m., ate.  G by the but not nutrition, n. first tic only; w, the only ived sidents	1436	3521.7(f)  This Statute will be met as evid by:  Reference response to W436.	denced	11/8/19 Ungoing

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Health F	Regulation Administra	ation					10.0	HAPPROVED
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0035			(X2) MULT A. BUILDIN B. WING	-	JCTION		LETED :
NAME OF 6	ROVIDER OR SUPPLIER	HF1203-0038	STORET AD	DRECC CITY	STATE, ZIP CO	DE	10/	16/2009
	JAL DEVELOPMENT,	INC.	431 63RD	STREET, S	E			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTIVE ACTION SHO REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(XS) COMPLETE DATE
	Interview with the disurvey revealed that keep her shoes on. Review of Resident October 8, 2009, at consult dated Septe indicated mild discoleft toes. A prescrip custom made shoes Interview with the lic #2 on October 8, 20 revealed that an appscheduled nor was order. After the intescheduled for custom the Residence Dire irregularities in the rescribing phys. This Statute is not reasonable to assure that compliance with the of six residents residents residents.	irect care staff during it the resident does in #4's medical record 1:45 p.m., revealed ember 11, 2009. The dorations on the 4th solorations on the 4th solorations on the 4th soloration was written for as sensed practical nurs 209 at approximately pointment had not be she aware of the physiciew, an appointment minoided shoes.  NS ector shall report any esident 's drug regimiscian.  met as evidenced by: and record review, the starded Person's (Gall drugs are administ physician's orders, for the resident's orders, for the resident's orders, for the resident's orders, for the resident is orders.	on a podiatry consult and 5th a pair of 2:00 p.m. sen sician at was	l 436	3522.4 This States: Reference		ridenced	lil8.09 ongon
	#3, #4 and #6) The findings include  1. The nursing staff if #4's order as prescrito the resident's hea	failed to administer Fi bed which posed a li Ith and safety.	kely risk					
	<ul> <li>a. Observation of the administration on Octoor Administration</li> </ul>	ed						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING B. WING	PLE CONSTRI	UCTION	COM	SURVEY LETED R
	HFD03-0025	ATTENTO		+. 70		10	/16/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT,	INC.	431 53RD	STREET, SE TON, DC 20		DDE		
PREFIX (EACH DEFICIENCY	YEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU REFERENCED TO THE APPR DEFICIENCY)	JUD BE	(X5) COMPLETE DATE
Resident #4 was ad units at 6:45 p.m. (Sigurcophage 1000 miles and the correct Administration Recording physicians orders of the Resident was promitted before dinner of the Resident was promitted before dinner of the Resident was promitted before dinner of the Resident was promitted by the Resident was promitted by the Resident was provided by the Resident was provided by the Resident order. Further observation revealed by the Surveyor why she disordered, she stated order. Further observation for the MAI insulin 5 units would not on October 7, 20 physician.  There was no document that the nurse made order did not start or prescribed.  b. Review of Resident 2009 at approximate telephone order date. The order the resident documented, "Debro both ears twice daily equal to 10 doses of removal."  Further review of resident purposes of the Resident purposes."	ministered Novolog SQ given at 90 degrand, and Os-Cat 200 responding Medication ord and October 200 no October 7, 2009, mescribed Novolog in October 7, 2009. The with LPN #1on Callowing the medication of the saked by the control of the saked by the saked by the control of the saked by the saked by the control of the saked by the sak	ee angle), rig. 9 evealed sulin 5  October 7, on olog bruary se as f the new 7, 2009 nurse volog 2009 and e the record e that the stober 8, led a 4:20 p.m. sich drops to should	{  473}				
Health Regulation Administration STATE FORM		441	<b>9</b> 97	N612		15	lon sheet 25 of 33

Health F	legulation Administra	ation				, , , ,	APPROVED
STATEMEN AND PLAN	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:  HFD03-0035			(X2) MULT A. BUILDII B. WING			R
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET A			DRESS CITY	STATE, ZIP CODE		16/2009
MIDDODUAL DEVELOPMENT (NO. 431 53RE			STREET,	SE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	record, Resident #4 doses ordered.  c. A record of Reside 2009, at approximate telephone order for at 4:30 p.m. According was to receive "Del drops in left ear twice should equal to 10 c.  Further review of reading at a failed to 10 c.  Further review of reading at a failed to 10 c.  General Reside 2009, at approximate order date January Shoulders daily."  Further review of Reside 2009, at approximate order date January Shoulders daily."  Further review of Remarks from February 23, 2004).  During a face to face October 8, 2009, at a revealed that Reside consult in January 21 unable to locate the interview. She acknows not receiving the	ordered. According received nine of the received nine of the lent #4's record on Cately 11:30 a.m. revealing to the order, the brox optic drops 6.59 a day for 5 days (vidoses of medication) cord revealed a MAF documented that the oladminister the tensident #4's record on Oaly 3:00 p.m. revealed a MAF documented that the oladminister the tensident #4's record on Oaly 3:00 p.m. revealed a catelogy 2:009 for "Head a day 2:009 for "Head a day and Shoulders the was an ordered date of the catelogy and a dermated the catelogy and a dermated the catelogy and shoulders the catelogy and shou	ctober 8, aled a st 4, 2009 resident % instill 4 which	[1 473]	DEPICIENCY		
:	treatments daily as prescribed.  2. During the entrance conference on October						
ealth Regulat	ion Administration		L				

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PRINTED: 11/02/2009 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-0035 10/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE INDIVIDUAL DEVELOPMENT, INC. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID PREFIX (XS) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG {| 473} Continued From page 26 (1473) 14, 2009, at 1:33 p.m., the registered nurse (RN) indicated that Resident #3 received a new physician order for eye drops. Review of Resident #3's medical records on October 14. 2009 at 2:30 p.m. revealed a telephone order for Gentamicin eye drops, four times a day to both eyes, dated October 7, 2009 at 5:00 p.m. According to the MAR, the Resident received Gentamicin (generic eye drops) sulfate 30 mg/ml. two drops in each eye twice a day, beginning October 9, 2009 through October 14, 2009. Interview with the RN on October 14, 2009 at approximately 3:00 p.m., confirmed the Resident received two eye drops twice a day. There was no evidence that the facility's medication nurse administered Resident #3's eye drops as ordered (four times a day). 3. Review of Resident #6's medical record on October 8, 2009, at 4:15 p.m., revealed a telephone order dated May 18, 2009. The order was for Augmentin 500 mg by mouth, twice a day for 15 days (30 doses). Review of the Resident's medication administration records (MARs) on October 8, 2009 at approximately 4:30 p.m. revealed that the Resident received the medication beginning on May 18, 2009, during the evening medication administration through May 31, 2009. Further review of the MAR's revealed that the Resident received 27 doses of the prescribed medication. Additionally the registered nurse (RN) was interviewed on October 8, 2009 at approximately 5:10 p.m., to ascertain information regarding the location of the June 2009 MAR. The RN could did not retrieve the June 2009 MARs. By the end

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of the survey, the RN failed to locate and provide

the June 2009 MAR for review.

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Health F	legulation Administra	ation					
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0035			(X2) MULT A. BUILDIN B. WING			SURVEY LETED R /16/2009
NAME OF S	ROVIDER OR SUPPLIER	11. 050,000	RTREET AD	DRESS CITY	STATE, ZIP CODE		10/2009
	JAL DEVELOPMENT,	INC.	431 53RD	STREET, S	3E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PRÉFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETE DATE
{I 473}	Continued From page 27  There was no evidence that Resident #6 received the prescribed doses of the antibiotics.			{i 473}	÷		
	Based on interview and record review the facility failed to assure that all drugs are administered in compliance with the physician's orders, for one of three residents included in the sample. (Resident # 1)						
	and General Emerg Instructions dated A revealed that she w (boil). Further revie revealed a physicial 2009. According to Bactrim OS Suspen be administered via (for upper lip abscer- was prescribed for 7 indicated that Bactri initially administered and discontinued or (8 days). Interview a approximately 12:15 Bactrim OS Suspen	esident #1's medical sency Department Discuss 25, 2009 at 1 as diagnosed with a w of the medical reconcern order, dated August the physician 's ordesion 20 ml was present of the twice a day its). Although the me days, the August 20 m OS Suspension 2 on August 26, 2009 a September 2, 2009 with the RN Supervision 20 ml was present of 20 ml was present of the two supervisions and the two supervisions and the two supervisions are the two supervisions and the two supervisions are two supervis	scharge 2 noon Furuncle ord st 25, er, cribed to for 7 days dication 009 MAR 0 ml was 1 at a.m. at 7 p.m. sor at that				
	be administered via Additionally, the RN had been administered. Review of the Re and General Emerginstructions dated Signaturations dated Signaturation Diagnosistion Administration	verified that the med red for 8 days. sident #1's medical ency Department Dis eptember 9, 2009 red d a "Primary Diagnoste, status post surge	records icharge vealed sis:				

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PRINTED: 11/02/2009 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI	PLE CONSTRUCTION  G	(X3) DATE S	ETED	
	HFD03-0035			B. WING _		1 7	२ 6/2009
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		<u> </u>
NDIVIDU	ANDIVIDUAL DEVELOPMENT, INC.  431 53RI WASHING				E 0019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{1 473}	Continued From pa	ge 28		{  473}			
	Tertiary Diagnosis: Complication-postoperative infection." The Emergency Discharge summary recommended "Keflex 500 mg Twenty eight: one capsule every 6 hours for 7 days," Review of the physician telephone order dated September 9, 2009 revealed Keflex 250 mg/5 ml suspension 10 ml P.O. Q 6 hrs x 10 days for abscess.  Review of September 2009 MAR on September 30, 2009 at approximately at 1:00 PM revealed Keflex 250 mg (5 ml suspension) 10 ml Q 6 hours x 10 days was not documented as administered on September 13, 2009 at 6 p.m.  Interview with the RN Supervisor at approximately 1:15 p.m. acknowledged that						
	approximately 1:15 Keflex 250 mg/5 ml		.O. Q 6				
	Home for Mentally F	all drugs are adminis	HMRP) stered in or three				
ľ	The findings include:						
	On October 14, 2 registered nurse (R) received a new phys Review of Resident : tton Administration	N) indicated that Res sician order for eye d	ident #3 rops.		:		

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Health F	Regulation Administra	ation					
	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0035			(X2) MULTI A. BUILDIN B. WING			LETED R
		HFD03-0035				10/	16/2009
NAME OF P	ROVIDER OR SUPPLIER			*	STATE, ZIP CODE		
INDIVIDU	JAL DEVELOPMENT,	INÇ.		STREET, S. STON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
	revealed a telephor drops, four times a October 7, 2009 at 2009, at 2:30 p.m. administration recorreceived Gentamici 30 mg/ml two drops beginning October 2009. Interview wit at approximately 3:1 resident received two There was no evide medication nurse addrops as ordered (fit 2. The nursing staff prescribed for Residual risk to the a. A review of Residual risk to the a. A review of Residual risk to the A face to face intervishe gave Novolog insulin 5 units before on October 7, 2009, the surveyor why shordered. She stated order ". Further obs	ne order for Gentamiday to both eyes, da 5:00 p.m., on October According to the merds (MARs), the clier in (generic eye drops in each eye twice a 9, 2009 through October 00 p.m., confirmed the RN on October 00 p.m., confirmed the voleye drops twice a ence that the facility's dministered Resident our times a day).  If failed to administer dent #4, which posed client's health and so client's health and so lent #4's record rever 7, 2009 which ordenits before dinner at siview with LPN #1 revinsulin 4 units as previous 10 p.m. revealed the mew order of Ne dinner to start at 5:  When LPN#1 was a led din not give the 5 to " I was not aware of the man order of the MAR for the Novolog r to start on October 100 p.m. revealed the MAR for the Novolog r to start on October 100 p.m. revealed the MAR for the Novolog r to start on October 100 p.m. revealed the MAR for the Novolog r to start on October 100 p.m. revealed the MAR for the Novolog r to start on October 100 p.m. revealed the MAR for the Novolog r to start on October 100 p.m.	ted ar 14, dication at a) sulfate day, ober 14, r 14, 2009 as day.  t #3's eye  order as a afety. aled an red 5:30 p.m. ealed that riously dication tober ovolog 30 p.m. asked by units as f the new 7, 2009 nurse g insulin 8, 2009	{1 473}			
	physician. Ition Administration		A		:		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION (DENTIFICATION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
HFD03-0035			B. WING _		I 1	R 10/16/2009		
			DRESS, CITY, S	STATE, ZIP CODE		WE5005		
				STREET, SE STON, DC 20019				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETE DATE	
{  473}	Continued From page 30			{1 473}				
	There was no documented evidence in the record that the nurse made the physician aware of the order not starting on October 7, 2009 as prescribed.				; •			
	b. A record review October 8, 2009 of Resident #4's record at approximately 11:00 a.m. revealed a telephone dated a telephone ordered dated July 21, 2009 at 4:20 p.m. which ordered, " Debrox ear drops 6.5% 5 drops to both ears twice daily for five days (which should equal to 10 doses of medication) for wax removal."							
	July 2009 which doe nursing staff failed to	e record revealed a le cumented that the fa- to administer all ten of Resident #1 receive ed.	cility loses of		· : :			
	Resident #4's record revealed a second to dated August 4, 200 "Debrox optic drops	on October 8, 2009 of d at approximately 1: selephone order for D 09 at 4:30 p.m. order 6.5% instill 4 drops ys (which should equ 1)."	1:30 a.m. Debrox read in left ear		:			
	August 2009 which nursing staff falled t	cord revealed a MAF documented that the o administer the ten sident #1 received n	facility doses of	:	: :			
	Resident #4's record	in October 8, 2009 of d at approximately 3; ate January 30, 2009 rs dally."	00 p.m.		:		·	
iestin Regula STATE FORM	ition Administration		<u> </u>	B.	TN612	<b>Y</b> continue	sheet 31 of 33	

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		(X1) PROVIDER/SUPPLIE	THE LA					
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP IDENTIFICATION				ULTIPLE CONSTRUCTION LDING			SURVEY LETED
HFD03-0035				B. WING			10	R /16/200 <del>9</del>
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADD	ORESS, CITY, S	TATE, ZIP CO	DE		
INDIVIDUAL DEVELOPMENT, INC. 431 53RD WASHING			431 53RD WASHING	STREET, SE TON, DC 20	E 1019			ļ
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(XS) COMPLETE DATE
Find the state of	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 31  There was no documented evidence that Resident #4 received treatment of Head and Shoulders daily.  Further review on the record revealed MAR's from February 2009 through October 2009 which documented that Resident #4 had treatments of the Head and Shoulders three times a week (which was an ordered dated from February 23, 2004).  During a face to face interview on October 8, 2009 at approximately 4:55 p.m. with LPN #2, she revealed that Resident #4 had dermatology consult in January 2009 however she was unable to locate the report at the time of this interview. She acknowledged the finding.  3. Review of Resident #6's medical record on October 8, 2009 at 4:15 p.m. revealed a telephone order dated May 18, 2009. The order was Augmentin 500 mg by mouth, twice a day for 15 days. Review of the resident's medication administration records (MARs) on October 8, 2009 at approximately 4:30 p.m. revealed that resident received the medication beginning on May 18, 2009 during the evening medication administration through May 31, 2009. Further review of the MARs revealed that the resident received 27 doses of the prescribed medication.  Inquiry was made with the registered nurse (RN) on October 8, 2009 at approximately 5:10 p.m., of the June 2009 MARs were. The RN could did not retrieve the June 2009 MARs were not available for review.			(1 473)		DEFIGENCY)		
th	here was no eviden e prescribed doses in Administration	ce that Resident #6 of the antibiotics.	received					

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Health F	Regulation Administra	ation						MINOVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED R 10/16/2009			
HFD03-0036			B, WING						
			STREET ADD	STREET ADDRESS, CITY, STATE, ZIP CODE					
				31 53RD STREET, SE VASHINGTON, DC 20019					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH GORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(XS) COMPLETE DATE	
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